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Smoking Cessation and the Role of Stigma

A Systematic Review

by

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MSW Clinical Research Paper

Presented to the Faculty of the

School of Social Work Program

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St. Paul, Minnesota

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Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Table of Contents

Abstract	3
Introduction	4
Literature Review	5
Methods	20
Research Synthesis	23
Discussion	27
Limitations	28
Further Research and Implications	28
References	30
Appendix A: Summary of Articles	35

Abstract

There have been smoking cessation programs in existence for more than three decades. Stigma has been used in smoking campaigns with good results for individuals in higher socioeconomic status, but not for those in poverty. Perceptions of smokers and behaviors of smokers continue to be stigmatized. This paper reviews the existing literature in an attempt to understand what role stigma plays in smoking cessation programs for those living in poverty.

Introduction

The prevalence of smoking in the United States is reported at 42 million adults, or 17.8% of the population in 2013, according to the Centers for Disease Control and Prevention. This number has declined from 1998 when 24.1% of the population smoked (CDC, 2015). Between 1998 and 2013 anti-smoking legislation and public health campaigns targeted cigarettes. Many campaigns contribute to the decline in smoking among the general adult population due to these prevention efforts. In contrast, since these policies and campaigns have been put into place, the number of people living in poverty who smoke has been relatively unchanged. The US defines “poor” as anyone living below their income threshold. It is easier to explain how many people in the US are living in poverty or “poor.” According to the Census Bureau 2014 report, 14.8% of the population was living in poverty. The CDC reports those who live below the poverty level have a smoking rate of 29.2%, which is significantly higher than 17.8% of the entire population. This percentage has not changed dramatically for smokers who are poor.

This literature review attempts to look closer at the consequences of smoking in both health as well as financial consequences of smoking. The literature then looks at smoking bans that have been put into place at both the federal and state levels and how this has impacted smokers. Once the smoking bans were put into place it looks at how this has been taken a step further by healthcare clinics across the country. Following the bans and changes to policies the literature then looks at initiatives used to assist with smoking cessation followed by the personal responsibility aspect, which smokers may view as helpful or hurtful. The literature also

looks at community supports that have been used and healthcare support. The final thing the literature looks at is what role stigma plays in smoking cessation and how it may have been helpful for some to quit smoking, but may have caused other to continue.

Consequences of Smoking

The health consequences of smoking are substantial and 480,000 deaths are caused from smoking related illnesses each year. Smokers are more likely than nonsmokers to develop heart disease, stroke, and lung cancer. Cancer risks can be increased in several areas of the body due to smoking. The financial cost of smoking related to health care cost and lost productivity, is staggering. The CDC reported the financial costs of smoking is nearly \$170 billion a year, the cost in lost productivity is nearly \$150 billion a year, and \$5.6 billion lost in productivity by secondhand smoke (CDC, 2015).

Stigma has been used to motivate people to quit smoking; however, research suggests that stigma may not motivate smokers across all socioeconomic levels. The purpose of this systematic review of the literature is to examine the role that stigma plays in smoking behaviors of those living in poverty.

Literature Review

According to the Center for Disease Control there are 6 million deaths worldwide from tobacco use and 480,000 deaths per year in the United States from smoking cigarettes (CDC, 2016). Policies have been put into place at federal, state, and local governments to limit the

dangers of secondhand smoke. As healthcare agencies continue to meet the needs of patients who suffer from the effects of smoking, they began to make their campus smoke free. Some healthcare agencies went as far as not to hire smokers. The literature looks at what is being done to help individuals to stop smoking and what has not been effective. This literature review attempts to look at how some individuals are able to stop on their own while others struggle. This review of the literature also attempts to let the reader see when and how the societal shift about smoking changed, as well as, increased efforts by groups such as the American Lung Association and the American Cancer Society who have lobbied to keep individuals away from the dangers of secondhand smoke.

Smoking Bans

According to the Centers for Disease Control, a smoke free law that is effective in eliminating the dangers of secondhand smoke must consist of banning smoking in indoor areas of worksites, restaurants, and bars (Centers for Disease Control [CDC], 2015). In 2000, there were no states with smoke free bans, but by 2010 there were 26 states with bans in place (CDC, 2015). There are states that have implemented smoking bans, but have not met the CDC's definition of a comprehensive plan and continue to have laws that do not eliminate Second Hand Smoke dangers (CDC, 2015). Many of the current smoking laws and smoking bans have changed the behaviors of smokers. Places where individuals were once free to smoke as they pleased have now become smoke-free areas. Smoke-filled taverns that were once commonplace are now free of the smoke and have areas outdoors where a smoker must go to

have a cigarette. Indoor public areas that once had ashtrays have now replaced them with no smoking signs. This has drastically changed the behavior of individuals who currently smoke.

Minnesota enacted its Minnesota Clean Indoor Air Act (MCIAA) amendments on October 1, 2007, to protect employees, as well as the public, from the dangers of secondhand smoke. MCIAA continues to be amended to include further clarification of the act (Minnesota Department of Health [MDH], 2015). The Freedom to Breathe Act prohibits smoking in virtually all indoor public places and indoor places of employment including bars, restaurants, private clubs, office and industrial workplaces, retail stores, common areas of rental apartment buildings, hotels and motels, public transportation, including taxis, work vehicles, home offices with one or more on-site employees, or uses a workplace to meet or deal with customers- during work hours, public and private educational facilities, and auditoriums and meeting rooms (MDH, 2015). The law does not prohibit smoking in the outdoors or private places such as private homes, residences, or automobiles when they are not being used as a place employment or sleeping rooms of hotels and motels. This law also does not prohibit smoking in commercial motor vehicles, family farm buildings or farm trucks or patients of licensed residential healthcare facilities in designated separate enclosed areas that meet applicable regulations. Responsibilities of the proprietors is to make reasonable efforts to prevent indoor smoking, post "no smoking" signs, ask persons who are smoking in prohibited areas to refrain from smoking and to leave if they refuse to do so, use lawful methods consistent with handling disorderly persons for any person who refuses to comply after being asked to leave the premises, refrain from providing ashtrays and other smoking equipment, and refused to serve noncompliant persons (MDH, 2015).

According to the World Health Organization and their Framework Convention on Tobacco Control, they report there is a trend towards smoke free outdoors (World Health Organization, 2015). This report explains that cigarette butts have been a growing health concern around the world, especially for children and wildlife, and states that have passed smoke free legislation for indoor areas are in a better position to pass outdoor bans as well. This report also notes that several private companies, as well as medical centers, continue to make their properties smoke free. The article explains this as an important step in educating youth about the dangers of tobacco, as well as eliminating the cigarette filters from accumulating on their property.

Hiring Policies

With smoking bans in affect, some hospitals and clinics have decided to take things a step further. According to a 2013 article from the New England Journal of Medicine, a small but increasing number of large clinics and medical universities have begun establishing policies for not hiring smokers. According to the article, these institutions can justify their policies by taking a stand against a dangerous habit. They feel they are sending an important message to young people and communities that they are reducing future medical costs. They may also be creating injustices by not hiring from those in lower socioeconomic groups who are the largest population of smokers (Asch, D. A., Muller, R. W., & Volpp, K. G. (2013). Is the debate about where someone smokes or if they smoke? Asch (2013) suggests that 70% of smokers would like to quit smoking and that these smoke-free hiring policies have made a difference in the number of smokers in the area. The article further suggests that stigma may have played a role in this

decline. The question to consider is, are these policies helping or hurting those who smoke (Asch, 2013)? In another study conducted in California, it was the job-seeking unemployed who had the highest rate of smoking prevalence compared to other employed groups (Prochaska, J. J., Shi, Y., & Rogers, A., 2013). There have been few studies that have investigated smoke-free policies at individual or community levels, and how this may contribute to a negative or positive view of smokers in places of employment and social settings (Prochaska, 2013).

Initiatives for Smoking Cessation

For the purpose of this review, smoking cessation interventions have been broken into public health campaigns and resources for quitting. One early example of a large public health campaign is the Great American Smokeout which began in the 1970's and was originally started as a local event to encourage people to quit smoking and donate money to a scholarship fund. By 1977, this campaign had gone nationwide and eventually became D-Day, or Don't Smoke Day (American Cancer Society, 2015). This campaign is credited for leading a path for changing how society views tobacco advertising and tobacco use. Over the decades since the first Great American Smokeout, several other public health campaigns have been attempting to make strides in changing attitudes about smoking, understanding nicotine addiction, and learning how to help people quit (ACS, 2015). The Center for Disease Control web site features examples of individuals who have used different methods to help them quit smoking. One example was a man who viewed himself as someone who had never smoked while he was attempting to quit. He reported this was helpful for him and allowed him to see his life as a non-smoker. The CDC is

supportive of the Great American Smokeout and reports that having a quit day can be the first step in quitting smoking.

A research article published in the American Journal of Public Health titled “Smoking-Cessation Media Campaigns and Their Effectiveness among Socioeconomically Advantaged and Disadvantaged,” explained that: “Overall, neither keep-trying-to-quit nor secondhand smoke ads were associated with quit attempts or smoking abstinence. Keep-trying-to-quit ads were significantly more effective in promoting quit attempts among higher, versus lower, educated populations”. This research allows us to see that there are differences in effectiveness among advantaged and disadvantaged populations and there is a need to address both populations if smoking cessation programs want to help everyone (Niederdeppe, J., Fiore, M. C., Baker, T. B., & Smith, S. S., 2008).

Personal Responsibility

Some individuals feel that it is their personal responsibility to kick the habit. An article in the *Journal of Health Communication*, “*On Being Responsible: Ethical Issues in Appeals to Personal Responsibility in Health Campaigns*,” suggest personal responsibility is common in many health communication campaigns and there are dangers of “Blaming the victim” for their habit (Guttman, N., & Ressler, W. H. 2001). Many individuals can purchase over-the-counter nicotine patches, nicotine gum, nicotine lozenges, and several other products that can assist to kick the smoking habit. Many of these products start at a higher dose of nicotine and taper down to less and less nicotine until the craving has subsided in the individual and they no longer need the product (Nicorette, 2016). Other individuals have been able to kick the habit

“cold turkey,” meaning that they decide never to pick up another cigarette again. This has been successful for some, but for others it is a struggle and they are unable to stop smoking.

One qualitative research article from Australia asked, “Why do smokers try to quit without medication or counselling? (Smith A. L., S. M. Carter S. M., Chapman S., Dunlop S. M., Freeman B., 2015). The research reported that when tobacco smokers quit, between half and two-thirds quit unassisted. That is, they do not consult their general practitioner (GP), use pharmacotherapy (nicotine-replacement therapy, bupropion or varenicline), or phone a quit line. Smith’s and colleague’s (2015) study found that “along with previously identified barriers such as use of cessation assistance (cost, access, lack of awareness or knowledge of assistance, including misperceptions about effectiveness or safety), our study produced new explanations of why smokers quit unassisted.” They found that they prioritize first-hand knowledge gained directly from personal experiences and indirectly from others over theories and educational material. They found that it was cheaper to quit unassisted. They believe quitting is their personal responsibility and they perceive quitting unassisted would increase their self-identity or self-image. Personal and societal values such as independence, strength, autonomy and self-control appear to be influencing smokers’ beliefs and decisions about quitting” (Smith et. al, 2015).

This research helped explain the reasons for smokers’ quitting on their own. Many misperceptions or treatment barriers are not the sole reason for not getting help. These findings suggest that general population could recognize and modify brief interventions to support their preference for quitting unassisted (Smith et. al, 2015).

Although some are able to stop smoking without the medical model or without the use of smoking cessation aids, while others need further support and assistance of the community.

Community Support

The Mariam Webster Dictionary defines community as: A group of people who live in the same area (such as a city, town, or neighborhood), and also defines it as: To show that you approve of (someone or something) by doing something: or: To give help or assistance to (someone or something) (Mariam Webster Dictionary, 2015). Community supports are available to help individuals to stop smoking. Quick Plan is one website that provides resources within all communities to assist with helping individuals become smoke-free. It offers individuals with text messaging and reminders as well as advice and encouragement to help individuals quit. They provide free resources that include two weeks of free patches, gum, or lozenges to help get started. They offer a quick guide that will assist smokers with a plan to quit (QuitPlan, 2015). Quitter's Circle which is another online support group sponsored by the American Red Cross. Not only does this website offer support for individuals who are attempting to quit smoking but it also gives tips on how to maintain abstinence from tobacco.

Smoking trends were examined from 2002 through 2006 in four Asian communities served by the Racial and Ethnic Approaches to Community Health (REACH) intervention. Researchers took prevalence of current smoking for men in two Vietnamese communities, 1 Cambodian community, and one Asian American/Pacific Islander (API) community. They were examined and compared with nationwide US and state-specific data from the Behavioral Risk Factor Surveillance System. The results showed a prevalence of current smoking decreased

dramatically among men in REACH communities. The reduction rate was significantly greater than that observed in the general US or API male population, and it was greater than reduction rates observed in the states in which REACH communities were located (Liao, Y., Tsoh, J. Y., Chen, R., Foo, M. A., Garvin, C. C., Grigg-Saito, D., & ... Giles, W. H., 2010).

A research article titled “Barriers and Facilitators to Expanding the Role of Community Health Workers to Include Smoking Cessation Services in Vietnam,” by Shelley, D., Nguyen, L., Pham, H., VanDevanter, N., & Nguyen, N. 2014), showed that other countries struggle to help smokers. They were able to see that despite high smoking rates, cessation services are largely unavailable in Vietnam. This study explored attitudes and beliefs of community health workers (CHWs) towards expanding their role to include delivering tobacco use treatment (TUT), and potential barriers and facilitators associated with implementing a strategy in which health centers would refer patients to CHWs for cessation services.

They conducted four focus groups with 29 CHWs recruited from four district community health centers (CHCs) in Hanoi, Vietnam. They found that participants supported expanding their role, saying that it fit well with their current responsibilities. They further endorsed the feasibility of serving as a referral resource for providers in local CHCs, expressing the belief that CHWs were "more suitable than their clinical colleagues" to offer cessation assistance. The most frequently cited barrier to routinely offering cessation services was that despite enacting a National Tobacco Control Action plan, cessation is not one of the national prevention priorities. As a result, CHWs have not been "assigned" to help smokers quit by the Ministry of Health. Additional barriers included lack of training and time constraints.

This showed that focus groups suggest that implementing a systems-level intervention that allows providers to refer smokers to CHWs is a promising model for extending the treatment of tobacco use beyond primary care settings and increasing access to smoking cessation services in Vietnam. They report there is a need to test the cost-effectiveness of this and other strategies for implementing TUT guidelines to support and inform national tobacco control policies in Vietnam and other low-and middle-income countries (Shelley, D., Nguyen, L., Pham, H., VanDevanter, N., & Nguyen, N., 2014).

Health Care Support

There are hundreds of resources to help individuals to stop smoking. Many medical institutions offer free services to assist with smoking cessation. Some of these services consist of groups of individuals who are also trying to quit smoking as well as meeting one-on-one with the smoking cessation therapist. Many of the smoking cessation programs are free of charge to patients. Many medical institutions understand the health risks associated with tobacco and are willing to help their patients to live a healthier lifestyle. Medical doctors, as well as therapists and addiction counselors, are available in medical settings to assist patients with a quit plan that is individualized to the patient's needs. A research article titled "Activating Patients for Smoking Cessation through Physician Autonomy Support", by Williams, G. C., & Deci, E. L. (2001), wanted to "test whether physicians' counseling patients for smoking cessation with autonomy supportive rather than controlling style would increase patients' active involvement in the counseling session and increase maintained abstinence." The results showed "physician style did not have a significant direct effect on smoking cessation, but did significantly increase

patient active involvement in the interview. Active involvement, in turn, increased smoking cessation". This was an important finding. Although doctors may not be directly able to encourage their patients to quit smoking, they are able to increase their patients' active involvement. This may be important for family and loved ones to assist with smoking cessation with family and friends as well as other medical and nonmedical disciplines (Williams & Deci, 2001).

Research on smokers and physician relationships continues to evolve. One research article titled "Support for Smoking Cessation Interventions in Physician Organizations: Results from a national study" by McMenamin, S. B., Schauffler, H. H., Shortell, S. M., Rundall, T. G., & Gillies, R. R. 2003), found that the level of support physicians provide could be improved through external incentives such as free nicotine replacement starter kits. The use of external motivators is not used by all healthcare agencies. The research concluded that further research would need to be done to see what external motivators would work best for certain populations (McMenamin et. al, 2003).

Stigma

With supports being put into place to assist with smoking cessations obstacles should be addressed along the way. One obstacle to smoking cessation is stigma. According to Meriam Webster Dictionary, a stigma is "a set of negative and often unfair beliefs that a society or group of people have about something" or "a mark of shame or discredit", (Meriam-Webster, 2015). Stigma is found to play a role in people quitting smoking. Once smokers were glamorized and smoking ad campaigns were seen on Billboards with famous people selling

tobacco products. Society's views have shifted from one of Glamour to distaste. An article in the Journal of Social Policy reports there is a decline in cigarette smoking in high income countries that is attributed to the increasing social unacceptability of smoking (Graham, 2011). In other research articles it is discussed that stigma is an explicit policy tool that may effectively reduce the prevalence of smoking behavior. It states that stigma is linked to tobacco- related morbidity and mortality in that it is therefore not necessarily antithetical to public health goals (Bell, K., Bell, J., Salmon, A., Bowers, M., & McCullough, L., 2010).

If individuals in the general population are able to get the help they need to quit smoking, there is a high chance of (Graham, 2011). There are many resources available. People who have health insurance and can have the time away from work to get the help they need, can find affordable resources. It may be much easier for the general population to notice the change in society's view of smoking and make the changes themselves. Communities or individuals who are poor, and are living in poverty may not have the time or access to the resources. They may not be as flexible to change with society's views of smoking. The addition of stigmatization may make it more difficult for individuals who are living in poverty to want to attempt to quit smoking (Graham, 2011). An article published in 2009 believes the only way to help smokers living in poverty is to improve living conditions in order to promote smoking cessation (Peretti-Watel, P., Seror, V., Constance, J., & Beck, F., 2009). The Peretti-Watel et. al, 2009) research article found:

Specific types of neighborhoods and poor housing conditions (described as cramped housing in a noisy and stressful environment or deprived neighborhood), which were

closely correlated with socio-economic status, were found to be significantly correlated with smoking, even after adjusting for potential key confounders and especially for individual markers of social disadvantage (p. 1).

A longitudinal study on the impact of income change and poverty on smoking cessation found smoking habits increased when income drop below the poverty threshold. The research also noted that when a smoker's income went above the poverty threshold they were more likely to quit smoking (Young-Hoon, K., 2012). This research allows us to see how poverty is a driving force behind smoking.

There are clinical guides and perinatal cooperatives to assist pregnant mothers with stopping smoking, but there are few programs to assist fathers with kicking the habit. Many people have seen a pregnant woman having a cigarette and have wondered what damage it is doing to the child. One research article looked at the pressures fathers may face while smoking and the difficulties this can bring to the relationship. The research article; *Unclean fathers, responsible men: Smoking, stigma and fatherhood*, (Greaves, L., Oliffe, J. L., Ponir, P., Kelly, M. T., & Bottorff, J. L., 2010), concluded: "That the lack of interventions and resources tailored to support fathers' smoking cessation may inadvertently increase relationship tension and place undue pressure on female partners to regulate fathers' smoking." This research opens the door to parents being stigmatized, not only by the public, but by family members as well.

One article "They don't live in my house every day: How understanding lives can aid understandings of smoking", Robinson & Holdsworth (2013), supports that stigma is becoming a problem for smokers:

However the focus on smoking as a harmful behavior can adversely affect the health of others has led to the (un)intended consequence of stigmatizing not only the act of smoking, but the smokers themselves (Bayer & Stuber, 2006; Bell, McCullough, Salmon, & Bell, 2010; Kim & Shanahan, 2003). This has meant that many smoking cessation services are finding it harder to engage with people who smoke and support people to remain nonsmokers once they have quit (Robinson, J., & Holdsworth, C., 2013, p. 1).

The struggles that individuals face with quitting smoking has been difficult without stigma being involved, and this article shows that including stigma into smoking cessation can add to the difficulty. The Robinson article also makes us aware that people generally do not begin smoking to increase their health risk, but for several other reasons. This may be why health reasons do not resonate with smokers. The article explains that other motivators may work better for individuals who are attempt to quit and that learning about why individuals smoke may prove to be more effective in helping them quit.

A research article by Flint & Novotny (1997), found similar results. The article suggests, “Smokers below the poverty threshold continue to be at risk to be current smokers and not to have quit smoking,” (Flint & Novotny, 1997). The data reflects the experience of smokers in poverty has not changed over time.

Stigma can play a large role in smoking cessation and research is beginning to show that poverty can make things even more difficult. A research article called “Poverty as a Smoking Trap,” by Peretti-Watel, P., Seror, V., Constance, J., & Beck, F. (2009), found links to poverty and smoking. They stated that: “Between 2000 and 2007 the social differential in smoking rates

increased sharply in France. Specific types of neighborhoods and poor housing conditions, which were closely correlated with socio-economic status, were found to be significantly correlated with smoking.” The research article suggests that interventions work, but the current interventions work primarily for those not living in specific types of neighborhoods or poor housing. The article concludes by saying, “interventions which do not specifically target smoking but which contribute to improving poor smokers' living conditions are necessary to promote smoking cessation” (Peretti-Watel, 2009). This research explains that targeting smoking in poor smokers is not enough, it is poverty that will need to be addressed as well. Better living conditions, higher education, access to healthcare, and higher pay, may all lead to better outcomes for smoking cessation programs.

An analysis of eight cross-sectional national surveys titled “Poverty status and cigarette smoking prevalence and cessation in the United States, 1983-1993: The independent risk of being poor,” conducted by Flint, A. J., & Novotny, T. E. (1997), found that “persons below the poverty threshold continue to be more likely than those at or above the threshold have not quit and continue to be current smokers.” They concluded that “poverty could be an indicator of why participation in smoking cessation programs and how changing social norms regarding smoking behavior could be influencing this lack of participation.” They reported that “further understanding of the relation between poverty and smoking is essential to develop effective programs for this population” (Flint, 1997). If programs are to be setup that will address smoking cessation among those living in poverty, it is essential to have a better understanding of what role stigma plays.

Research Question and the purpose of systematic lit review

My research question is what role does stigma play in smoking cessation among those living in poverty? The purpose of this research is to understand if stigma is playing a negative role in helping individuals to quit smoking who are poor or living below the poverty line. A recent study “Tobacco Control Stigma and Public Health Rethinking the Relations” explores the role of stigma in smoking behavior. The research asks whether stigma is helpful for everyone to stop smoking or is it leading others to continue to smoke and increasing their risk of smoking related illnesses (Bayer, R., & Stuber, J. 2006, p. 1).

Methods

For the purpose of this systematic literature review, smoking refers to cigarettes only and no other tobacco products such as vapor cigarettes, cigars, or pipes. This review looked at all smokers and did not differentiate between men and women or age. This study looked at what positive, as well as negative, effects stigma has with smokers and smoking cessation.

Type of Studies

To answer the question of what role does stigma plays in smoking cessation only empirically based quantitative and qualitative studies were considered including: case studies, and in-depth interviews. The focus of this study was on how stigma affects smoking cessation among those living in poverty.

Search Strategies

The preliminary search of academic journals and online search sites included SocINDEX, Google Scholar, PsycInfo, and Pubmed.gov. In order to understand the scope of available literature around the research question, a search for both specificity and sensitivity was conducted. A search of sensitivity allows researchers to examine the largest range of research topics ((Hutchinson J., 2015). This level produced a great deal of available research and a big percentage of irrelevant articles. A search of specificity allows researchers to narrow the focus of research in order to produce a search with a high percentage of usable articles ((Hutchinson J., 2015). A specificity search runs the risk of missing relevant articles due to the limits of the search terms. Using both sensitivity and specificity searches will help to better understand the literature landscape in order to narrow down search terms, as well as to develop inclusion and exclusion criteria. Both searches for sensitivity and specificity were used as part of this study (Hutchinson J.C., 2015).

Review Protocol

Peer-reviewed, full-text articles were considered in this review. Because stigma can be used in smoking cessation and also be a result of such programs, society's shift in how smokers are viewed by the public, is a relatively new topic of research. Dissertations published within the last 10 years were included in this literature review. Articles were found using the search engines PsycINFO, Alt HealthWatch, Academic Search Premiere, ProQuest Dissertations & Theses, Google Scholar, and PubMed. Articles were searched and collected during February of

2016. These data qualifications were put into place as a means of addressing the issue of validity for this research.

Inclusion Criteria

In the database of PsycInfo and AltHealthWatch, , Academic Search Premiere, ProQuest Dissertations & Theses, Google Scholar, and PubMed searches were carried out using the following combination of search terms; “stigma” or “smokers” or “smoking stigma” or “stigma among smokers” AND “cessation” or “smoking cessation and stigma” or “stigmatized smoker” or “cessation and stigma” or “poverty and stigma” or smoking and poverty” or “poverty.” All articles that came up with these databases, using these search terms, were published after 2000.

Exclusion Criteria

Of the 52 peer-reviewed articles and dissertations that met the initial search criteria, only 9 met the criteria to be included in this literature review. Articles that were excluded from the research review were: studies that focused on electronic cigarettes; articles that focused on all tobacco products; and ones that did not meet the criteria specified above. Other articles that were excluded from this study are ones that included persons under 14. Selected articles were also limited to those written in English.

Inclusion and exclusion decisions were made based on the content of the articles and dissertations. The final review consisted of 9 peer-reviewed articles and dissertations. A detailed list of included articles with content summary can be found in Appendix A.

Research Synthesis

The purpose of this systematic literature review was to explore the question: What role does stigma play in smoking cessation for those who live at or below the federal poverty line? Ten peer-reviewed articles and dissertations met criteria and were reviewed. Of the 10 articles included in this study, nine (90%) were focused on strictly smoking without including other substances. The one article that did not focus solely on smoking included alcohol in conjunction with smoking.

Thematic Analysis

Through analysis of the literature, three main themes emerged from this systematic review around what role stigma is playing in smoking cessation of those living in poverty. The themes included; 1) The Role of Stigma and Smoking Behavior, 2) The Role of Stigma and the Perception of Smoking, 3) The Role of Stigma and Smoking Cessation.

Role of stigma and smoking behavior

Four research articles discussed the role of stigma and smoking behavior. Stuber, Gelea, Link (2009), in a cross-sectional, random-digit-dial, general-population telephone survey of exactly 4,000 New York City residents age 18 or older found “perceived devaluation, perceived differential treatment due to smoking, social withdrawal from nonsmokers, and concealment of smoking status. The results suggest that stigmatization of smokers is a potentially powerful and

unrecognized force, that may be counterproductive” (p. 585). The research examined New York’s 2003 implementation of its smoke-free-air laws, which eliminated smoking in all restaurants and bars (Stuber, Gelea, Link, 2009).

Thomas, Pearce, and Barnett (2007), researched moralizing geographies: stigma, smoking islands and responsible subjects, conducted in Christchurch, New Zealand. The study consisted of twenty six interviews, reported “the increasing stigmatization of those who continue to smoke, coupled with spatial segregation of poor and minority populations, may compound to produce ‘smoking islands’ that may serve to reinforce rather than discourage continued smoking” (p. 508). The research argued that much more careful thought needs to be given to the effects of multiplying stigma (Thomas, Pearce, and Barnett, 2007).

Hemsing, Greaves, Poole, and Bottorff (2012), investigated secondhand smoke exposure and management in the context of smoking locations to understand gender and income related differential effects of restricting smoking locations (p. 1). In this study 47 individuals participated in a telephone interview or focus group. The research reported that based on the findings, “smoking restrictions have resulted in a reshaping of both the social and physical environment. Participants described a reshuffling and relocating of where people are smoking, bringing new challenges both for smokers and for those managing smoke exposure” (p. 13). They went on to explain, “approaches needed that prevent further marginalization of the groups most vulnerable to smoking and SHS exposure” (p. 13).

Pearce, Barnett, and Moon (2012), suggest that “if individuals are residing in a depressed urban environment is a factor in encouraging smoking, then attempts at individual

behavioral changes are likely to fail, unless the nature of those environments also changes” (p. 17). This research suggests the way to helping smokers in poverty to quit smoking is to help them out of poverty. This article provided an overview and critique of existing research. .

The role of stigma and the perception of smoking

Three of the articles discussed the role of stigma and the perception of smoking. Farrimond’s and Joffee’s (2006), thematic analysis had participants two conceptual maps of their images of smokers and nonsmokers. The aim was to elicit participants’ spontaneous ‘first thoughts’ concerning smokers and nonsmokers. The research had forty participants between 20 and 60 years of age, with varied socio-economic and smoking status. The research identified “several areas of stigmatization of British smokers by non-smokers: identification of negative aesthetic ‘marks’ of smoking and of smokers as ‘polluters’ who harm others; the display of direct and indirect social disapproval; and the association of smokers with out-groups such as single mothers” (p. 1). The research reported, “higher SES smokers tend to challenge the stigma, whereas lower SES smokers internalize the stigma” , (p. 1).

Voigt’s (2012), research of hiring policies and tobacco control discussed the ethical concerns in tobacco control hiring policies. The research concluded that smoking is increasingly concentrated among disadvantaged groups who are also more susceptible to job insecurity. These findings suggest that such policies must also be assessed from a social justice perspective (Voigt (2012).

Stuber’s, Galea’s, and Link’s (2008), cross-sectional research of connection between smoking, stigma and social status, found

structural forms of discrimination perpetrated against smokers and former smokers (e.g., company policies against hiring smokers)” are associated with smoker-related stigma (p. 420). The research goes on to suggest stigma is an important point of leverage in the role of smoking epidemic and raises concerns about the possible role of stigma in production of smoking disparities”, p. 420).

The role of stigma and smoking cessation

Two articles discussed the role of stigma and smoking cessation. Kim (2014), explains in his research that when he showed smoking ad videos as well as stigmatizing campaign videos to research participants, there was an unintended effect on smokers who belong to lower economic status and also have less self-efficacy in quitting smoking, happened. The research showed that the shaming effect of the video had a stronger impact on the cessation behavior of smokers with higher income while it gave those in lower income categories reduced levels of cessation intention. This suggests that anti-tobacco campaigns need to look at developing interventions based on social economic status if they are to be effective for all populations (Kim, J. 2014).

Warner’s (2009), systematic review research article argues that the differential burden of stigma upon smokers who are already disadvantaged has implications in terms of their human dignity and the likely effectiveness of health campaigns. She goes on to say for those in public health who are concerned with reducing smoking rates, there is a crucial distinction between the act of smoking- which they say is what is stigmatized through health campaigns- and smokers themselves (Warner, 2009).

Discussion

This systematic review was developed to explore the contemporary body of scholarship available on the topic of the role of stigma in smoking cessation among those living in poverty. What emerged from this review is current anti-smoking campaigns are not effective for smokers who are living in poverty. These findings suggest that anti-smoking campaigns need to limit stigma and build programs that are effective for all socio-economic classes.

The themes found in this literature focused on the negative impacts of anti-smoking campaigns and the role stigma played within the campaigns on those living in poverty. Those who live in poverty are already stigmatized and while smoking becomes socially unacceptable those who are in poverty are either unable or unwilling to stop smoking.

Anti-smoking campaigns have been used for the last three decades, and while there has been a decrease in smokers across the US, the number of smokers living in poverty has remained relatively unchanged. The research points to the use of stigma as a possible reason for smokers who are living in poverty to not stop smoking. The use of stigma to help a population, who may be stigmatized for multiple reasons, has shown through the research, to be a poor tool in moving them towards a smoke free life. The use of stigma in public health campaigns may lead to making things worse for smokers who live in poverty through discrimination in hiring policies and other unintended consequences.

Limitations

While this review was designed to include all relevant contemporary research on the topic of what role stigma plays in smoking cessation for those living in poverty, there were still a number of limitations to this study. While the dangers of smoking have been known for several decades little research has been done on the role stigma plays in smoking cessation programs.

How stigma works in smoking cessation programs is a fairly new subject and a limited amount of research has been done on this subject. This review was limited to research and articles that were peer-reviewed and written in the English language. The purpose of this was to ensure the rigor of the study but may have left out structured research focused on individual experience and less formal narrative. Evidenced-based, peer-reviewed articles were the focus of this study and literature that has not been formally published was excluded from this study. The importance of peer-reviewed articles is they are reviewed by others in the area studied and are found to be worthy of publishing.

Implications for Social Work Research, Practice and Policy

One of the first things to emerge from this systematic literature was how limited the research is around the role of stigma in smoking cessation programs. These findings indicate that stigma limits the effectiveness of smoking cessation programs for those living in poverty. Smoking cessation education and advertisement has been utilized for a decade or more. It is necessary to conduct research specifically with those living in poverty in order to understand how programs can be modified to help those in poverty.

One reason for the limited nature of research could be access to the population. Research performed with those in poverty and who smoke may feel an additional layer of stigma and may be unwilling to participate in research studies. Many individuals who smoke and experience stigma hide their smoking and unwilling to discuss their smoking habit. Many smokers may not report their use for fear of being exposed to stigma from society, family, friends, and employer. Whatever the reason, it is clear that research around how to best serve and support this population is lacking.

As more research continues to be conducted on the subject of smoking and the role of stigma in smoking cessation programs there will be a shift in how services, treatments and programs to those in poverty, smoking cessation will be more effective.

The implications for social work will be the need to understand stigma for those in poverty and who are current smokers. Those living in poverty and who smoke may be experiencing multiple stigmas and may be sensitive to their smoking habit. Smokers in poverty may also be experiencing discrimination by agencies who are unwilling to hire them due to their smoking. It will be important to understand what would help them to quit smoking if they would like. Since modern form of smoking cessation programs are not effective form of motivation for those in poverty, it may be necessary to look for alternatives.

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Young-Hoon, K. (2012). A longitudinal study on the impact of income change and poverty on smoking cessation. *Canadian Journal of Public Health / Revue Canadienne De Sante'e Publique*, 103(3), 189-194

Appendix A: Summary of Articles

Citation	Research Question and Method	Sample	Key Findings	Implications for practice, policy and research
Stuber, J., Galea, S., & Link, B. (2009). Stigma and smoking: The consequences of our good intentions. <i>Social Service Review</i> , 83(4), 585-609	Do people who smoke think they are stigmatized? Quantitative	4,000 New York City residents over 18	Stigma comes in many forms It is not permanent, unless diagnosed illness due to smoking Stigma can be discriminatory	Future research to identify tobacco control policies that change social norms that do not produce stigma.
Farrimond, H. R. and Joffe, H. (2006), Pollution, peril and poverty: a British study of the stigmatization of smokers. <i>J. Community. Appl. Soc. Psychol.</i> , 16: 481–491. doi: 10.1002/casp.896	Are people in lower SES being further stigmatized? Qualitative	40 smokers and non-smokers between 20 to 60 years of age.	Higher SES challenge facts stigma is based on. Lower SES internalize the stigma aspersions Smoking is pollution and unclean/smokers poison others. Non-smokers view smokers as antisocial	None Noted
Thompson, L., Pearce, J., & Barnett, J. R.. (2007). Moralising Geographies: Stigma, Smoking Islands and Responsible Subjects. <i>Area</i> , 39(4), 508–517. Retrieved from http://www.jstor.org/stable/40346072	Why should people who are disadvantaged take up smoking or continue to smoke.	26 people interviewed between ages 14 and 70	Poor smokers Dual stigma Hygiene is a key player in class. Change in behavior related to passive	More careful thought needs to be given to the effects of multiplying levels of stigma, however

	Qualitative		smoking. Smoking is a form of taking control Individual level health risks are denied	unintentionally.
Hemsing, N., Greaves, L., Poole, N., & Bottorff, J. (2012). Reshuffling and relocating: The gendered and income-related differential effects of restricting smoking locations. Journal of Environmental and Public Health, , 907832. Retrieved from http://ezproxy.stthomas.edu/login?	Study investigate s second hand smoke exposure and managemen t. Qualitative	47 low income and non-low-income men and women of varied smoking statues.	“Residing in a low-income area or an area of physical disorder or deprivation has been linked to greater tobacco use. There have been debates among researchers over whether denormalization and stigma are effective tobacco control strategies”	Smoking restrictions for women and men at varied income levels and smoking status warrant future research and policy development
Voigt, K. (2012). Nonsmoker and "Nonnicotine" Hiring Policies: The Implications of Employment Restrictions for Tobacco Control. American Journal Of Public Health, 102(11), 2013-2018.	Journal Article	Journal Article	“denormalization strategies is that they may lead to, or exacerbate, the stigmatization of smokers. ^{32,33} Because denormalization strategies emphasize	Nonsmoker and nonnicotine hiring policies may damage, rather than support, the fight against smoking.

			that smoking is “undesirable, ” “abnormal,” and not part of “mainstream ” society”	
Pearce, J., Barnett, R., & Moon, G. (2012). Sociospatial inequalities in health-related behaviours: Pathways linking place and smoking. <i>Progress In Human Geography</i> , 36(1), 3-24. doi:10.1177/0309132511402710	Draw out how smoking is related to place, and examine how such links reciprocal and subject to broader issue of context and scale	Focus paper	Social disadvantage increase propensity to smoke. Area-level social deprivation and smoking behavior are linked through 2 distinct pathways: place based practice concerned with the act of smoking, and neighborhood regulatory measures that promote or inhibit smoking.	Future geographical research should pay attention to different scale effects, wider set of influences, specify group differences, and social environment. Cluster of smokers within socially disadvantaged groups including homeless, and mental illness.
Kim, J. 2014. Does Stigma Against Smokers Really Motivate Cessation? A Moderated Mediation Model on the Effect of Anti-smoking campaigns promoting smoker-related stigma on cessation intentions. Proquest dissertation publishing	Does Stigma Against Smokers Really Motivate Cessation? Qualitative	111 current smokers Age range from 19-62	Modifying current smoking campaign strategies that focus on demeaning smokers and smoking behavior. Stigmatizing	Use more diverse populations . Considers smokers professions. Commercial impact over a long period of time.

			campaigns elicited unintended effect on inhibiting cessation intentions, particularly among lower SES.	Larger sample size
Joanne Warner (2009). Smoking, Stigma and Human Rights in Mental Health: Going up in Smoke?. <i>Social Policy and Society</i> , 8, pp 275-286. doi:10.1017/S1474746408004788.	Systematic review	Systematic review	People in disadvantaged groups find it harder to give up in general. Long history of stigma in public health campaigns. Ideological and moral Poverty and smoking are strongly correlated	Research on harm reduction. Reduce stigmatizing effects.
Stuber, J., Galea, S., & Link, B. (2008). Smoking and the emergence of a stigmatized social status. <i>Social Science & Medicine</i> Volume 67, Issue 3, Pages 420–430	What are the determinants of stigma? Qualitative	816 current and former smokers in New York City	Fear of health consequences of SHS are important influence on smoking stigma. Hiring policies More education felt more stigma Family stigma	Need to understand stigma in the smoking epidemic more fully. Promote or not promote stigma

<p>Møller, V., Erstad, I., & Zani, D.. (2010). Drinking, Smoking, and Morality: Do 'Drinkers and Smokers' Constitute a Stigmatised Stereotype or a Real TB Risk Factor in the Time of HIV/AIDS?. <i>Social Indicators Research</i>, 98(2), 217–238. Retrieved from http://www.jstor.org.ezproxy.stthomas.edu/stable/40800968</p>	<p>Drinking, Smoking, and Morality: Do 'Drinkers and Smokers' Constitute a Stigmatized Stereotype or a Real TB Risk Factor in the Time of HIV/AIDS?</p> <p>Qualitative Research</p>	<p>1,020 adults living in low-income township In South Africa</p>	<p>TB and HIV are contributed to smoking, drinking and poor lifestyle Smoking is seen as unclean Smokers do not attend church as often. Moral risk factors visible in community and easy to scapegoat. Stigma exist in poverty and those smoking in poverty. The dirty unmoral poor.</p>	
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